MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, and family by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995)

I, Leigh Mackey, Coroner, having investigated the death of IM

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is IM. IM was born on 23 November 1984 and had two brothers and a sister. She was 37 when she died. She lived in New South Wales, where her parents still reside, before moving, with her husband BR, to Tasmania in 2017. She and BR established a home in Ulverstone where they were raising their three children at the time of IM's death;

b) IM died as a result of sepsis due to necrotising fasciitis, following abdominoplasty with liposuction;

c) IM's cause of death was sepsis; and

d) IM died on 12 May 2022 at Burnie, Tasmania.

The circumstances leading to death

For most of her life IM struggled with her weight. At her heaviest she weighed approximately 147kg. In response to her weight and whilst living in New South Wales IM had a gastric band inserted for weight loss. The band was subsequently cut and removed due to it slipping.

In late 2021 IM underwent a gastric bypass. She was quite ill following this procedure and was taken by BR to the Launceston General Hospital (LGH) where she was admitted for a further week before fully recovering.

As a product of the gastric bypass IM lost a significant amount of weight and was consequentially left with excess skin. She consulted a plastic surgeon, Dr Garry Kode and on 6 May 2022 underwent an abdominoplasty and liposuction under his care at Calvary St Vincent's Hospital (StVH). Following that procedure she remained an inpatient at StVH until

discharge on 10 May 2022. During the inpatient post operative period IM complained of significant pain. At the time of discharge she continued to complain of pain.

IM was discharged into the care of BR at approximately 10.30am. At that time and as described by BR, IM did not "look great" and was in a lot of pain. BR felt he needed to drive home as slowly and as smoothly as possible so as not to aggravate her pain. They returned to their home in Ulverstone via the local chemist to buy Panadol Osteo for pain relief. Once home IM's condition deteriorated. She struggled to eat and drink and found mobilising and sitting difficult. Her pain continued.

A telephone consultation was conducted between IM and her General Practitioner on 10 May 2022. At that consultation the history she gave was that Dr Kode had been called, he had no concerns regarding surgical complications, she was for review with him on the following Friday, she had ongoing pain and had run out of endone which had been working to moderate her pain. The existence of redness, fevers, signs of infection or abdominal concerns were specifically denied. An ePrescription for endone was provided by the General Practitioner to IM for the post operative pain.

On 11 May 2022 at 6.10pm BR checked on IM who was in the bedroom. He found her struggling to stand with no energy and he assisted her back to bed. BR was worried about her condition. He suggested that she go to hospital and told her that she might die. IM responded by telling him all she needed was to go to bed and lie down. IM requested he call Dr Kode. He did so and was told by Dr Kode to transport IM to Launceston. BR found it difficult getting his wife to the car to take her to the LGH due to her condition and experience of pain. At 7.30pm he called an ambulance to attend.

On arrival by Ambulance Tasmania IM was found to be cold, mottled and peripherally shut down. On arrival to the North West Regional Hospital (NWRH) she was assessed as having a Glasgow Coma Scale score of 12/15. In his report the Coronial Pathologist, Dr Ritchey, identified that at this time Im *"was in extremis with shock, decreased consciousness, severe metabolic acidosis and acute renal failure (sepsis syndrome). Despite intravenous antibiotics and fluid resuscitation she suffered progressive cardiovascular collapse and death the following morning*".[1]

I have had regard to the evidence gained in the comprehensive investigation into IM's death. The evidence includes:

- The Police Report of Death;

[1] Affidavit of Dr Donald MacGillivray Ritchey sworn 6 July 2022

- The Hospital Report of Death;
- The Affidavit of Dr Donald MacGillivray Ritchey sworn 6 July 2022;
- Police, family and witness affidavits;
- Medical records and reports; and
- Reports of Dr Anthony Bell.

Comments and Recommendations

I have considered if either the performance of the procedure or the decision to discharge IM caused or contributed to her death. I have been greatly assisted in considering these matters by Dr Anthony Bell, Medical Adviser to the Coroner. Dr Bell has reviewed the medical records of IM and on that basis has advised that in his opinion the decision to operate was reasonable given that she had redundant skin resulting from her significant weight loss. Further Dr Bell does not identify any issues of medical concern relevant to the performance of the procedure nor the decision to discharge IM. I accept his opinion in this respect.

Dr Bell describes in his report that necrotising fasciitis is "*an infection of the deep soft tissues that results in progressive destruction of the muscle fascia and overlying subcutaneous fat. Infection typically spreads along the muscle fascia due to its relatively poor blood supply; muscle tissue is frequently spared because of its generous blood supply…Initially, the overlying tissue can appear unaffected; therefore, necrotizing fasciitis is difficult to diagnose without direct visualization of the fascia. In the early stages the skin appearance would not be of concern.*"[2] Dr Bell further advises necrotising fasciitis can progress rapidly to cause systemic toxicity, limb loss and/or death. Accordingly early recognition of necrotising fasciitis is critical for survival.

At the time of her discharge the symptoms IM presented with were nausea, vomiting and a slight tachycardia. The nausea had responded to antiemetics and IM had been reviewed by the surgeon prior to leaving and was cleared for discharge. The history given at the telehealth consultation between IM and her general practitioner, as referred to earlier in these findings, identified her major issue as pain. Redness, fever, signs of infection or abdominal concerns were specifically excluded at that time. Following her discharge and particularly on 11 May 2022, IM's condition significantly and rapidly deteriorated.

Necrotising fasciitis is a rare complication of surgery.[3] It rapidly progresses to cause "extensive destruction" [4] of the body's systems. It can be difficult to diagnose.[5] Whilst IM's

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[2] Report of Dr Bell 4 December 2024 ps2-3
[3] Report of Dr Bell 4 December 2024 p3
[4] Report of Dr Bell 4 December 2024 p3
[5] Report of Dr Bell 4 December 2024 p3

experience of severe pain following her discharge and return home was likely caused by the presence and progress of necrotising fasciitis, the condition was an unusual post-surgical complication, rapidly progressed following her discharge from StVH and was difficult to diagnose.

The circumstances of IM's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of IM.

Dated: 29 January 2025 at Hobart Coroners Court in the State of Tasmania.

Leigh Mackey
Coroner